



Health Home Care Coordinators Training

Medicare Grievances and Appeals



HealthPath
Washington

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Washington State
Health Care Authority



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Developed and Presented by

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This presentation will describe the various Medicare programs and benefits. It will also review the process for filing an appeal with Medicare.

Training Objectives

- Provide an overview of basic Medicare programs and benefits
- Describe the grievance and appeals process and how to file a complaint
- Introduce beneficiary rights

This presentation will describe the various Medicare programs and benefits. It will also review the process for filing an appeal with Medicare.



Medicare

Basic Benefits



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- Medicare Basics
 - Part A, B, C, D and Original Medicare
- Medicare Appeals
 - How to File an Appeal
 - How to File a Complaint
 - What are Their Rights

Before I launch into a description of Medicare's appeal process, I'm going to give you some background on standard Medicare terminology. As the Medicare program progresses into the future, it is revised to include and exclude benefits and it is revised to expand the delivery systems for beneficiaries with Medicare coverage.

Medicare Benefits

- Medicare Benefits & Delivery Systems
 - Basics
 - Part A – hospital benefits
 - Part B – medical benefits
 - Part C – managed care delivery system
 - Part D – pharmacy delivery system and Medicare drug formulary
 - Original Medicare – means all of the above, except Part C and D, that is delivered Fee-for-Service

I'm not going to spend much time on this section but felt a short tutorial on Medicare terminology may help you when providing services to your Health Home clients. I recommend using the slide show as a cheat sheet.

Medicare is a national medical insurance program, administered by the U.S. federal government since 1966. It guarantees access to health insurance for Americans aged 65 and older who have worked and paid into the system, and younger people with disabilities as well as those with certain medical conditions, such as kidney disease and ALS.

Medicare benefits are broken out into three different categories – Part A is the hospital benefit, which was the first Medicare benefit to be instituted. Part B, which is the medical benefit came shortly thereafter. Part D was instigated the Bush Administration on January 1, 2006 and is used to describe both the delivery system for pharmacy and the pharmacy benefit itself. Part C is the name of Medicare's managed care delivery system and last is what they call "Original Medicare." Original Medicare is their FFS delivery system which is how Medicare benefits were delivered until the advent of Part C and D.

Why is this important? It is important because knowing what it means when someone talks about Part A, B, C, D or original Medicare means you have a better understanding of Medicare and how it works and fits together.

Part A

- Part A covers the following:
 - Inpatient care in hospitals
 - Inpatient care in a skilled nursing facility (not custodial or long-term care)
 - Home Health
 - Hospice
 - Inpatient care in a Religious Nonmedical health care institution

Part B

- Part B covers the following:
 - Medically necessary services such as:
 - Doctor services
 - Outpatient care
 - Durable Medical Equipment
 - Other medical services
- Part B also covers many preventive services such as
 - Immunizations

Part C

- Medicare Managed Care
 - Medicare Advantage
 - Medicare Advantage – Special Needs Plans

Part C is not a benefit but instead is the term used by Medicare to describe their managed care delivery system. They are a number of different types of Part C plans, but they are all managed care delivery systems.

Part D

- Part D is a Medicare delivery system designed to cover drugs
 - Part D stand alone health plan
 - Part D included as a portion of Medicare benefits in a Medicare Advantage plan

Part D is newer than A, B and C and is what Medicare calls their pharmacy benefit AND delivery system. Medicare didn't cover drugs under Part A or Part B, except in specific instances, such as getting an immunization at your doctor's office. If that was the case, then the immunization is included in the Part B benefit.

All Medicare beneficiaries are required to have Part D. That doesn't mean your elderly grandmother will be hunted down and forced to comply with the Federal rules. It means that if your elderly grandmother decides that the Federal government isn't going to tell her what to do, then she either pays for the drugs herself, goes without her medication or joins a Part D later than the enrollment period and pays a penalty to join.

Part D may be included as part of the benefits a beneficiary receives when they are in a Part C managed care plan. If their Part C managed care plan doesn't include Part D, then the beneficiary is in a stand-alone Part D plan. Any beneficiary who is on "Original Medicare," (FFS) also receives their pharmacy benefit through a stand-alone Part D plan.



Medicare



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Grievance and Appeals Process Beneficiary Rights

Medicare Appeals

- An appeal is the action a Medicare beneficiary can take if they disagree with a coverage or payment decision made by Original Medicare (FFS) or Medicare managed care (Part C or Part D)
- The usual course of action for an appeal is a denial of services

Now to the heart of the slide show – Medicare Appeals. The definition above comes directly from CMS. Usually a beneficiary appeals a denial of a service, but they may also appeal the cost of a service. As a Care Coordinator you may assist a client in seeking services using the Medicare benefit. You may provide education to your client and their representatives about rights and how to file an appeal. You may provide coaching or even complete the required steps to file an appeal on your client's behalf.

Medicare Appeals, cont.

The health home beneficiary may appeal if Medicare denies the following:

- A request for health care services, supplies, items, or prescription drug
- A request for payment for a health care services, supplies, items or prescription drugs they've already received
- A request to change the amount they are paying for a prescription drug
- Medicare (FFS) or Medicare managed care stops providing or paying for all or part of an item or service they think they still need

How to File an Appeal

How an appeal is filed depends on the type of Medicare coverage the health home beneficiary has. For health home beneficiaries they need to do the following:

- Get the Medicare Summary Notice (MSN) that shows the item or service that is being appealed
- Medicare beneficiaries get the MSN every 3 months that lists all the services billed to Medicare and tells them if Medicare paid for the service

For example, a beneficiary may file an appeal with their Part C plan or may file an appeal directly to Medicare if they are receiving benefits via Fee-For-Service (FFS). But regardless of whether or not a beneficiary is enrolled in managed care or on FFS, they all receive an MSN.

And, by the way, all of your beneficiaries who are entitled to Medicare appeals are receiving their MEDICAID and MEDICARE benefits through the FFS system, since we don't enroll full duals in managed care and health home services are not available to full duals who receive their care in a Medicare Advantage plan.

How to File an Appeal, cont.

- Circle the item they disagree with on the notice and write an explanation on the notice of why they disagree. They can also write an explanation on a separate page and send it in with the notice
- Sign, include their phone number, and provide their Medicare number on the notice
- Keep a copy of their documentation for their records

Their Medicare number will be on their official Medicare card they receive from CMS.

How to File an Appeal, cont.

- Send the notice, or a copy to the Medicare contractor's address listed on the notice
- They can send any additional information they want about their appeal
- They must file the appeal within 120 days of the date they get the MSN
- OR, they can use CMS form 20027, and file it with the Medicare contractor at the address listed on the notice. To view or print this form, visit www.medicare.gov/medicareonlineforms or call 1-800-Medicare (1-800-633-4227) for a copy of the form
- TTY users should call 1-800-486-2048

How to File an Appeal, cont.

- They will generally get a decision from the Medicare contractor (either in a letter or an MSN) within 60 days after the request was received. If Medicare covers the items, it will be listed on their next notice
- The State Health Insurance Assistance Program (SHIP) can also help if they need assistance filing an appeal

What Are Their Rights?

If they think services are ending too soon when getting Medicare services from:

- A hospital
- Skilled nursing facility
- Home health agency
- Comprehensive outpatient rehabilitation facility
- Or hospice

They can ask for a fast appeal

In certain circumstances a beneficiary may want to file a “fast appeal.” That means they need to have something resolved sooner than the 60 days it takes to respond or resolve a regular appeal.

What Are Their Rights? cont.

To ask for a fast appeal:

- Their provider will give them a notice before their services end
- The notice has instructions on how to ask for a fast appeal
- They should read the notice carefully
- If they don't get this notice, they may ask their provider for it

For example, a hospital will give them a notice that they will be discharged before they are actually discharged.

What are their Rights? cont.

With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO) will decide if services should continue

- The beneficiary may ask their doctor for information that may help their case
- They must call their QIO to request a fast appeal no later than the time shown on the notice
 - The QIO phone number is listed on their notice.
- If they miss the deadline, they still have appeal rights if they have original Medicare
- If that happens, they should call their QIO

Qualis is Washington's QIO.

How to File a Complaint

Medicare coverage entitles beneficiaries to quality healthcare and they are also guaranteed access to easy-to-understand information concerning:

- Filing a complaint about the quality of healthcare they've received in the past or are undergoing in the present
- If the concern is related to quality or necessity of care provided, and
- That care is covered by Medicare, and
- The care was provided in Washington or Idaho

Here is one more additional piece of information on Medicare Appeals and Grievances. A complaint in Medicare terminology is different than an appeal. A complaint is not filed when there is a denial of service or a dispute with payment. For example, a complaint would be filed if a beneficiary doesn't think their doctor prescribed the right drug and they got sicker because of a perceived mistake.

How to File a Complaint, cont.

– If the information on the previous slide is true, then the beneficiary may start the complaint process by filing out the Medicare Quality of Care Complaint form. To get a copy of the form, visit:

- <http://www.QualisHealthMedicare.org/people-with-medicare/file-a-complaint>

Once they've determined that they've met the criteria for filing a complaint they can fill out a "complaint form."

Certificate of Completion

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